Virginia Medicaid
ANTI-OBESITY DRUGS
Prior Authorization Request Form

Virginia Medicaid has coverage limits and criteria for prior authorization of weight loss medications. These limits and criteria are based on concerns about safety when used with other medications, and efficacy. In order for beneficiaries to receive Medicaid coverage for these drugs, it will be necessary for the prescriber to complete and fax or mail this prior authorization request to First Health Services Corp. at the address listed at the bottom of this form. Please complete this form in its entirety and sign and date below. Incomplete requests will be returned for additional information.

Use this form for Anti-Obesity drug prior authorization requests only.

Prescribing physician:

Name: _____

Phone #: _____

Fax #: _____

Beneficiary:

Name: _____

Medicaid ID #: _____

Date of Birth: _____ Sex: _____

Pharmacy (if known): _____ Phone: _____ &/or FAX: _____

Drug Requested: _____ Strength & Frequency: _____ Length of therapy: _____

Coverage for these medications will be limited to the following:

- Patients with a BMI >40 or more, or a BMI >35 or more with co -morbidity.
- Patient must be 18 years of age or older.

  Note: Patient must be eligible for coverage at the point of sale (determined by supplying pharmacy).

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1. Assessment: _____

_____

_____

2. Other Diagnosis: _____
3. Current medications: _____
4. Current body mass index (BMI): _____ Height: _____ Current Weight: _____
5. Are there any contraindications for this use, malabsorption syndromes, cholestasis, pregnancy and/or lactation?

   YES **NO** If YES, please describe: _____
6. Is this part of a total treatment plan including a calorie and fat restricted diet and exercise regimen?

   YES **NO** If YES, please attach copy of plan.
7. Have there been any previous weight loss plans or programs including diet and exercise plans?

   YES **NO** If YES, please attach copy of plan and reason for failure.

Comments:

Prescriber Signature: _____ **Date of this request:** _____

FOR FIRST HEALTH USE

Approved	**Changed**	**Denied**	**Pending**	**Comments:** _____
MAP RPh/tech: _____				_____
NDC: _____				_____
Date of Decisions: _____				_____

Submit requests via phone, fax or mail to:

First Health Services Corp.
MAP Dept.
4300 Cox Road
Glen Allen, VA 23060

Tel: 1-800-932-6648
FAX: 1-800-932-6651

DMAS-172